wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

How "medically necessary" is applied when evaluating prior authorization requests

Inside this Update:

A recent evaluation of the Wisconsin Medicaid prior authorization (PA) process by the Wisconsin Legislative Audit Bureau recommended that the Department of Health and Family Services (DHFS) issue guidance regarding how DHFS applies the concept of medical necessity in its evaluations of PA requests. The purpose of this *Wisconsin Medicaid and BadgerCare Update* is to provide guidance and additional information related to the PA review process. Future *Updates* will contain information on how the concept of medical necessity is applied to specific Medicaid-covered services.

All services are required to be medically necessary for reimbursement

Wisconsin Medicaid reimburses only medically necessary services and appropriate services listed in s. 49.46(2) and 49.47(6)(a), Wis. Stats., as implemented by HFS 107, Wis. Admin. Code, regardless of whether prior authorization (PA) is required or not.

Services requiring prior authorization

Prior authorization is required for certain Medicaid covered services before the services are provided to the recipient. Of all Medicaid services, less than 4% require PA before the service is covered. It is crucial that a provider include enough information on a PA request so that the Medicaid consultant reviewing the request can determine that the service(s) being requested meets all the elements of Wisconsin Medicaid's definition of "medically necessary."

Services requiring PA are identified in the service-specific handbooks and in HFS 107, Wis. Admin. Code.

Clinical review to verify that services are medically necessary

The PA attachment is the vehicle by which the provider documents that the service(s) is medically necessary. Providers must submit the appropriate PA attachment with the Prior Authorization Request Form (PA/RF). (Dentists are required to use the Prior Authorization Dental Request Form [PA/DRF] and hearing instrument specialists are required to submit the Prior Authorization Hearing Instrument and Audiological Services [PA/HIAS1] form instead of the PA/RF.) Providers may refer to their service-specific handbook for instructions on how to complete the attachment appropriate to their provider type.

For Wisconsin Medicaid, the term "medically necessary" is defined under HFS 101.03(96m), Wis. Admin. Code. Upon verifying the completeness of clerical items on the PA/RF

(refer to the "Clerical information to include on a prior authorization request" section of this article), the PA request is reviewed by a professional consultant to evaluate that each service being requested meets Wisconsin Medicaid's definition of "medically necessary."

Definition of "medically necessary"

Wisconsin Medicaid may only approve a PA request if ***all of the following standards*** of the definition of "medically necessary" are met.

As defined under HFS 101.03(96m), Wis. Admin. Code, "medically necessary" means a medical assistance service under ch. HFS 107 that is:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

(b) Meets the following standards:
   1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
   2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
   3. Is appropriate with regard to generally accepted standards of medical practice;
   4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
   5. Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;
   6. Is not duplicative with respect to other services being provided to the recipient;
   7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
   8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
   9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

This definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service.

This definition of "medically necessary" is a legal definition identifying the standards that must be met for approval of the service. The definition imposes parameters and restrictions which are both medical and non-medical. To determine if a requested service is "medically necessary" Medicaid consultants obtain direction and/or guidance from multiple resources including:

- Federal and State Statutes.
- Wisconsin Administrative Code.
- Prior authorization guidelines set forth by the Department of Health and Family Services.
- Standards of practice.
- Professional knowledge.
- Scientific literature.

Providers are encouraged to submit adequate documentation with PA requests to address these standards of medical necessity.

Examples of how medically necessary is applied to prior authorization requests

The following examples illustrate how each standard of the definition of "medically necessary" from HFS 101.03(96m), Wis. Admin. Code, might be applied to PA requests:

(a) Required to prevent, identify or treat a recipient's illness, injury or disability; and

Example: Personal care worker (PCW) services are a covered benefit of Wisconsin Medicaid. A PA request is submitted for PCW services to help a recipient with daily cares for four hours each weekday; however, the occupational therapy (OT) and physical therapy evaluations indicate the recipient is independent in all activities of daily living skills. In this situation, the Medicaid consultant may question if a PCW is actually required since the need for assistance of a PCW is not evident.

(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

Example: A PA request is submitted for a root canal. The recipient has an infection in his or her tooth; however, the structures surrounding the tooth are badly compromised. In this situation, the Medicaid consultant may question if a root canal is consistent with treatment of this condition.

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

Example: A PA request is submitted for OT because a recipient is having difficulty taking his or her medications properly. Occupational therapy to address cognitive deficits is a benefit of Wisconsin Medicaid. However, a physician, nurse, or pharmacist may be the more appropriate professional to teach, review, and/or monitor medication administration.

3. Is appropriate with regard to generally accepted standards of medical practice;

Medical professions generally have standards for practice and/or other regulatory requirements. The services provided by each medical professional (and the subsequent written documentation of the service in the recipient's medical record) should be of sufficient detail and content so that the expertise and knowledge of the medical professional is evident. An evaluation of a patient or client is not acceptable if it does not include complete testing, findings, and/or interpretation, or is simply the reiteration of another professional or caregiver's report.

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms

or other medically necessary services being provided to the recipient;

Example: A PA request for speech and language therapy is submitted to address drooling. A review of the PA request indicates that the recipient is taking medication where a side effect of the medication is increased saliva often resulting in drooling. In this situation, the Medicaid consultant may question if therapy would be of any clinical benefit, since the condition being treated may be a reaction to the drug and will most likely continue until use of the drug is discontinued.

5. ***Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;***

Example: A PA request for speech and language therapy includes facilitated communication. This treatment technique is considered experimental. "The scientific validity and reliability of Facilitated Communication have not been demonstrated." (American Speech-Language-Hearing Association. [1995, March]. Position statement-facilitated communication. *ASHA*, 37 [Suppl.14], pp. 22.)

6. ***Is not duplicative with respect to other services being provided to the recipient;***

Example: A PA request is submitted for a power wheelchair. A review of the PA requests on file for the recipient indicates that Medicaid previously paid for a power scooter for the recipient. In this situation, the Medicaid consultant will question if a second mobility device is necessary or duplicative of the previously approved request for the scooter.

7. ***Is not solely for the convenience of the recipient, the recipient's family or a provider;***

Example: A PA request is submitted for a liquid nutrition supplement for a recipient, but there is no documentation of the recipient's inability to eat a regular diet. In this situation, the Medicaid consultant would question if the product is medically necessary or a convenience to make meal preparation easier.

8. ***With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and***

Example: A PA request is submitted for a mobilized stander that hydraulically lifts the recipient from a seated position to a standing position. It is necessary for this recipient to stand; however, the wheels and hydraulic lift on the requested stander are additional features that add about $2,000 to the cost of a basic stander. Since the wheels and hydraulic lift do not augment the physiological benefits of standing, the motorized hydraulic lift

stander may be denied, and a less expensive stander for this recipient could be approved.

9. ***Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.***

   Example: A PA request is submitted for therapy services to provide range-of-motion exercises. A review of the recipient's record indicates that range-of-motion exercises are included in the recipient's home health aide's Plan of Care. Therefore in this situation, the consultant may question if the requested additional services can safely and effectively be provided to the recipient.

To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

The determination of medical necessity is based on the documentation submitted by the provider. For this reason, it is essential that the documentation is submitted completely and accurately and that it provides the justification for the service requested, specific to the recipient's current condition and needs. To be approved, a PA request must meet all of the standards of medical necessity including those that are not strictly medical in nature.

Clerical information to include on a prior authorization request

The Legislative Audit Bureau evaluation of the Medicaid PA process indicated that clerical errors are responsible for two-thirds of the cases where a PA must be returned to a provider for correction or additional information. Since having to return a PA request for corrections, or additional information can delay the prompt approval and delivery of services to a recipient, providers should ensure that all clerical information is correctly entered on the PA/RF and that all clinical information necessary to document that the service is medically necessary is included.

When requesting PA, providers are required to submit a PA/RF (PA/DRF or PA/HIAS1 when appropriate). The PA/RF functions as a cover sheet and asks for general information regarding the provider, the recipient, and the service(s) for which PA is being requested. The validity of the clerical information is checked by answering questions such as:

- Is the recipient currently eligible for Wisconsin Medicaid?
- Does the recipient's Medicaid identification number match the recipient's name?
- Does Wisconsin Medicaid cover the service being requested?
- Is there a current physician's prescription for the service attached, if required?
- Is the billing provider number included and correct?

The provider must ensure that all information is complete and correct. Prior authorization requests are legal medical documents; therefore, Wisconsin Medicaid staff cannot add or change any information indicated on PA/RFs (e.g., writing the provider number in the correct box on the request).

For additional information

Providers should verify that they have the most current sources of information regarding PA. It is critical that providers and staff have access to these documents:

- Wisconsin Administrative Code: Chapters HFS 101-108 are the rules regarding Medicaid administration.
- Wisconsin Statutes: Sections 49.43-49.497 provide the legal framework for the Medicaid program.
- All-Provider Handbook: This handbook gives general information on the Medicaid program, provider certification, coordination of benefits, eligibility, claims submission, PA, and more.
- Service-specific handbooks: These handbooks give detailed information on what services are covered for a provider type, what services require PA, and how to submit claims for services.
- *Wisconsin Medicaid and BadgerCare Update*: This monthly publication gives the latest policy changes for all providers and for specific provider types.
- Managed Care Provider Handbook: This handbook is necessary for providers of services to any Medicaid managed care enrollees.

Providers may also contact Provider Services at (800) 947-9627 or (608) 221-9883 or refer to the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/* to obtain these materials and/or obtain more information.

Managed care providers

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements. ✦

What's new on the Medicaid Web site

The Wisconsin Medicaid Web site includes provider and recipient publications, Medicaid contacts and statistics, and eligibility and benefit information. You may visit the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

The following is a list of what has recently been added to the Medicaid Web site:

- November 2001 *Wisconsin Medicaid and BadgerCare Update*.
- Updated Medicaid and BadgerCare caseload statistics.
- 1998-1999 HMO Comparison Report and Data Tables.
- Updated Pharmacy Handbook.

Keep in mind that if you do not have a computer with Internet access, many libraries have access available. ✦

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *www.dhfs.state.wi.us/medicaid/*.